EMT/FIRE STANDARDS STUDENT
ACKNOWLEDGEMENT OF HIPAA OBLIGATIONS

I understand that it is the intent of the CTAE/FSFC to safeguard and protect the privacy and security of its applicants, employees’ and patients’ “protected health information” as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
I understand that “protected health information” includes individually identifiable information, maintained or transmitted through any medium, relating to an individual’s past, present, or future physical or mental health or healthcare. Health information is considered individually identifiable if it either identifies a person by name or creates a reasonable basis to believe the individual could be identified (through identifiers such as address, Social Security number, dates of service, telephone number, email address or vehicle identification number).

In the course of my educational experience with CTAE/FSFC contracted agencies, I understand that I may come into contact with protected health information of applicants, employees, and patients. In consideration for my being allowed to ride-along with these contracted agencies, I hereby agree that I will not at any time (either during my assigned time with such agencies, or any time thereafter) access, use, or disclose to any person or entity, any protected health information of the contracted agencies applicants, employees, or patients.

I further understand it is the policy of the contracted agencies to ensure the confidentiality, integrity, and availability of protected health information entrusted to the contracted agencies by its applicants, employees, and patients by protecting those assets from unauthorized access, alteration, deletion, or unauthorized transmission and to ensure their physical security. In consideration for my being allowed to participate in education with these contracted agencies, I further agree that I will not make any unauthorized transmission, alteration, deletion, or unauthorized access of protected health information. Such unauthorized transmission includes but is not limited to, removing and/or transferring protected health information. Such unauthorized transmission includes, but is not limited to, removing and/or transferring protected health information in any agencies computer system to an unauthorized location. I understand that these privacy and security obligations apply, regardless of the manner in which I acquired the protected health information, whether it was communicated verbally, in writing, electronically, or in any format, and regardless of whether it was communicated directly to me or intended for my access. I understand that this obligation survives the completion of my educational experience with CTAE/FSFC contracted agencies no matter the circumstances whereby my experience is completed.

I understand that the unauthorized access, use, disclosure, alteration, deletion, or unauthorized transmission of protected health information in violation of this policy may subject me to immediate removal from all CTAE/FSFC contracted facilities or apparatus. I also understand that violating the privacy and security rights of individuals protected health information under HIPAA may also result in the imposition of civil/and criminal penalties and other sanctions provided by federal and state laws.

By, signing, and including today’s date below, I acknowledge that I have read and understand my obligations as a student of CTAE/FSFC to protect the privacy and security of protected health information relating to any applicant, employee, or patient.

Please mark one EMT/Fire Student

Name Please Print:____________________________________

Signature:____________________________________________

Date:________________________________________________
Immunization Form

Last Name ______________________________ First Name ____________________________ M ______

Address ________________________________________________________ Date of Birth ___________

Telephone (_____)________________________ Email Address __________________________________

Record your most recent immunizations (shots) and provide proof.

- MMR
  Documented proof of immunity to mumps, measles, and rubella is mandated by the state. Immunity to measles, mumps, and rubella is defined as follows:

  Mumps (no expiration date) Date: _____________________
  Proof of immunization or proof of positive titer

  Measles (rubeola) (no expiration date) Date: _____________________
  □ Born before 1957
  □ Documentation of receipt of two (2) doses of live Measles vaccine after the first birthday and no less than one month apart
  □ Physician diagnosed measles
  □ Documentation of immune titer (a blood test) proving immunity

  Rubella (no expiration date) Date: _____________________
  □ Rubella vaccine given after one year of age
  □ Documentation of immune titer (a blood test) proving immunity, or age greater than 40 years

- Chicken Pox/VZV (current immunization or proof of positive titer) Date: _____________________

- PPD (Tuberculin) (current within one year of graduation date) Date: _____________________
  IF YOU REFUSE A PPD OR IF YOU HAVE HAD A POSITIVE TB REACTION YOU MUST PRODUCE A CURRENT NEGATIVE CHEST X-RAY.
  □ Skin Test    □ Chest X-Ray

- Hepatitis B Date: _____________________
  All students must submit proof of current Hepatitis B vaccination, or must sign a stipulation declining immunization.
  Date: _____________________

- DTaP/DTP
  Dose 1 MM/DD/YY
  Dose 2 MM/DD/YY
  Dose 3 MM/DD/YY
  Dose 4 MM/DD/YY
  DOSE 5 MM/DD/YY
  Tdap Booster (1 time after 11 years of age) MM/DD/YY
  TD (within 10 years) MM/DD/YY

Signature of Student: ____________________________________________  Date: ____________________

COMPLETED IMMUNIZATION DOCUMENTATION MUST BE IN THE STUDENTS FILE PRIOR TO ENTERING ANY CLINICAL EXPERIENCE.  An Equal Opportunity School District
MEDICAL HISTORY FORM

Student Information

Student’s Name: ________________________________ Sex: _____ Age: ______ Date of Birth: ____/____/_________
Home Address: ___________________________________ Home Phone: (_____)_______________________
Contact in case of Emergency: _______________________________ Relationship to Student: ________________
Home No: (____) __________________ Work No: (____) ________________ Cell: (____)____________________
Personal/Family Physician: _____________________________________ City: ______________________________
State: ______________________________________ Office Phone: (____) ______________________________

Medical History:  **MANDATORY (to be completed by student)** Explain “yes” answers below. Circle questions you don’t know answers to.

**IMPORTANT: IT IS VERY IMPORTANT THAT THESE QUESTIONS ARE ANSWERED TRUTHFULLY AS YOUR SAFETY AND HEALTH IS OF PRIMARY CONCERN. WE CANNOT QUALIFY ANY STUDENT INTO OUR TRAINING PROGRAM IF THERE IS ANY PRE-EXISTING OR CURRENT MEDICAL CONDITION, INJURY, ILLNESS OR DEFICIENCY WHICH WOULD PROHIBIT YOU FROM PERFORMING THE TYPE OF PHYSICAL ACTIVITIES YOU WOULD BE ENGAGED IN DURING OUR TRAINING.**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you had a medical illness or injury since your last check up or sports physical?</td>
<td></td>
</tr>
<tr>
<td>2. Do you have ongoing chronic illness?</td>
<td></td>
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<tr>
<td>3. Have you ever been hospitalized overnight?</td>
<td></td>
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<tr>
<td>4. Have you ever had surgery?</td>
<td></td>
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<tr>
<td>5. Are you currently taking any prescription or non-prescription (over-the-counter) medications, pills or using an inhaler?</td>
<td></td>
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<tr>
<td>6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?</td>
<td></td>
</tr>
<tr>
<td>7. Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects) that require medical treatment?</td>
<td></td>
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<tr>
<td>8. Have you ever had a rash or hives develop during or after exercise?</td>
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<tr>
<td>9. Have you ever passed out during or after exercise?</td>
<td></td>
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<tr>
<td>10. Have you ever had dizziness or fainting spells?</td>
<td></td>
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<tr>
<td>11. Have you ever had chest pain during or after exercising?</td>
<td></td>
</tr>
<tr>
<td>12. Have you ever had racing of your heart or skipped heartbeats?</td>
<td></td>
</tr>
<tr>
<td>13. Have you had high blood pressure or high cholesterol corrected with meds? Or low blood pressure corrected with meds?</td>
<td></td>
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<tr>
<td>14. Have you ever been told you have a heart murmur?</td>
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<tr>
<td>15. Has any family member or relative died of heart problems or sudden death before age 50?</td>
<td></td>
</tr>
<tr>
<td>16. Has a physician ever denied or restricted your participation in sports for any heart problems?</td>
<td></td>
</tr>
<tr>
<td>17. Do you get tired more quickly than your friends do during exercise?</td>
<td></td>
</tr>
<tr>
<td>18. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?</td>
<td></td>
</tr>
</tbody>
</table>
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)?
   YES   NO

20. Have you ever had a head injury or concussion?
    YES   NO

21. Have you ever been unconscious or lost your memory?
    YES   NO

22. Have you ever had seizures, history of epilepsy or neurological disorders?
    YES   NO

23. Do you have frequent or severe headaches?
    YES   NO

24. Have you ever had numbness or tingling in your arms, hands, legs or feet?
    YES   NO

25. Have you ever become ill from exercising in the heat or heat related injury?
    YES   NO

26. Do you cough, wheeze or have trouble breathing during or after activity?
    YES   NO

27. Do you have asthma, chronic bronchitis or lung disease?
    YES   NO

28. Have you had any problems with your eyes or vision?
    YES   NO

29. Do you wear glasses, contacts or protective eyewear?
    YES   NO

30. Have you ever had stomach, liver or intestinal problems?
    YES   NO

31. Have you broken or fractured any bones or dislocated any joints?
    YES   NO

   If yes, check appropriate blank and explain below:
   YES   NO

   ______ Head    ______ Elbow    ______ Hip
   ______ Neck    ______ Forearm   ______ Thigh
   ______ Back    ______ Wrist     ______ Knee
   ______ Chest   ______ Hand      ______ Shin/Calf
   ______ Shoulder ______ Finger    ______ Ankle
   ______ Upper Arm ______ Foot

32. Do you want to weigh more or less than you do now?
    YES   NO

33. Do you feel stressed out?
    YES   NO

34. Have you ever been diagnosed with Sickle Cell Anemia or any other blood related disorder?
    YES   NO

35. Have you ever been diagnosed with Sickle Cell?
    YES   NO

36. Are you pregnant?
    YES   NO

Explain “yes” answers here:
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Student Signature: ___________________________ Date: ___________________________
RELEASE AND WAIVER OF LIABILITY
FLORIDA STATE FIRE COLLEGE

I acknowledge that attendance and/or participation in the activities at the Florida State Fire College involves a risk of bodily harm and injury and I assume all risk. I hereby agree that for consideration of the use of the facility, equipment, programs, grounds, and personnel of the Florida State Fire College, I hereby waive liability, and release and forever discharge the Florida State Fire College, the Florida State Fire Marshal, and the Department of Financial Services and its employees, officers, and agents individually from any and all claims, demands, rights and causes of action of whatever kind or nature, arising out of all known and unknown, foreseeable and unforeseeable bodily and personal injuries, damage to property, and the consequences thereof; including death, resulting from participation in or in any way connected with any classes, training, or use of the Florida State Fire College, its property or its equipment.

I further agree that for the consideration stated above, I will indemnify, hold harmless and covenant not to sue the Florida State Fire College, the Department of Financial Services, the Florida State Fire Marshal, and its employees, officers or agents for any claim for damages or causes of action whatsoever and by whomever made arising or growing out of my participation in the activities or use of the Florida State Fire College, its property or its equipment. I agree that this waiver and release shall include myself, my heirs, executors and assigns, whether such personal injury, death or property damage was caused by the negligence of the Florida State Fire College, the Department of Financial Services, the Florida State Fire Marshal, or any of its employees, officers, or agents. Further, I understand that this release, waiver of liability, and covenant not to sue shall be effective for any events occurring during the entire period of my enrollment or use of the Florida State Fire College.

I have received a copy of this document and I certify that I am of legal age, I am suffering under no legal disabilities, and that I have read the above carefully or had the above read to me before signing.

____________________________________  ____________________________
Signature                                      Date

____________________________________
Print Name

____________________________________
Course Title
School Board of Marion County, Florida
Release and Waiver of Liability

I, ____________________________ acknowledge that attendance and participation in a course of training involves a risk of bodily harm and injury. I hereby agree that, in partial consideration for participation in training involving the use of the Florida State Fire College, clinical sites, or School Board facilities or equipment, that I will be solely liable and I expressly release and forever discharge, and hold harmless the School Board of Marion County, Florida, and its employees, officers, and agents, from any and all claims, demands, rights, causes of action of whatever kind or nature, arising out of all known and unknown, foreseeable and unforeseeable bodily and personal injuries, damage to property, and the consequences thereof, including death, resulting from my participation in or in any way connected with said training.

I further agree that I, my spouse, my heirs, distributees, guardians, legal representatives and assignees will not make any claim against, sue, or prosecute the School Board of Marion County, Florida, or any other affiliate organizations, employees, officers and agents for injury or damage resulting from negligence or other acts, howsoever caused, by any employee, agent, or contractor of the School Board as a result of my participation in course activities. I further understand that this release and waiver of liability shall be effective for any events occurring during the entire period that I am present on the grounds of the Florida State Fire College and/or clinical sites or using any equipment belonging to the State of Florida and/or the Marion County School Board.

I hereby state that I am fully informed regarding the general dangers and risks of my participation in course training activities. I further release all agents and employees of the Marion County School Board from any claim whatsoever arising from first aid and medical services rendered to me as the result of my participation in all course training and clinical site activities, and I agree that I am financially responsible for the medical treatment and emergency services that I receive.

I further certify that I am of legal age, and suffer under no undisclosed disabilities. I acknowledge that this is a legal document, which I have read and voluntarily signed. I agree that no oral representation or statements and inducements apart from the foregoing written agreement have been made to me.

________________________________________  __________________________
Student Signature                          Date

______________________________
Printed Name

An Equal Opportunity School District